



Return To:  
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## COLLABORATING PHYSICIAN FORM

### DEMOGRAPHIC INFORMATION

Mid Level Practitioner Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Specialty Trained: \_\_\_\_\_ Group NPI No: \_\_\_\_\_  
 Group Name: \_\_\_\_\_ Tax ID: \_\_\_\_\_  
 Office Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

### COLLABORATING PHYSICIAN INFORMATION

(IF THERE ARE MORE COLLABORATING PHYSICIANS THAT NEED LISTED, PLEASE ATTACH TO THIS FORM)

Collaborating Physician Name: \_\_\_\_\_  
 Collaborating Physician Specialty: \_\_\_\_\_  
 Collaborating Physician Name: \_\_\_\_\_  
 Collaborating Physician Specialty: \_\_\_\_\_  
 Collaborating Physician Name: \_\_\_\_\_  
 Collaborating Physician Specialty: \_\_\_\_\_  
 Collaborating Physician Name: \_\_\_\_\_  
 Collaborating Physician Specialty: \_\_\_\_\_  
 Collaborating Physician Name: \_\_\_\_\_  
 Collaborating Physician Specialty: \_\_\_\_\_

\_\_\_\_\_  
 Signature, Mid Level Practitioner

\_\_\_\_\_  
 Date